Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: HUNTSVILLE MEMORIAL HOSPITAL C/O CARDON HEALTHCARE 8610 S SANDY PKWY STE 100 SANDY UT 84070	MFDR Tracking #:	M4-09-5879-01
Respondent Name and Box #: Texas Mutual Insurance Co. Box #: 54		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The patient was treated in the emergency room for an injury he sustained while at work. We are requesting that our claim be paid for the following reasons:

- At the time of admit, the hospital was informed that Aetna was the proper insurance company to be billed. On 2/19/08, a claim was sent to Aetna.
- On 3/5/08, Aetna processed and paid the claim.
- On 09/24/08, Aetna retracted the payment.
- On 10/6/08, a claim was sent to Texas Mutual.
- On 10/16/08, 10/30/08 and 11/24/08 we called Texas Mutual and were informed by the automated system that the claim was processing.
- On 1/5/09, the hospital received another letter from Aetna stating that Texas Mutual is the proper insurance to be billed.
- On 1/14/09, we called Texas Mutual and spoke with Rosalin Doss. We were informed that no bill was on file. We faxed a bill along with proof of timeliness to Texas Mutual.

The attached hospital notes, medical records and copies of submitted claims support what is stated above. The charges are fair and reasonable."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $828.10
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary:

"1. The requestor provided services 2/10/08, the date of the compensable injury. The requestor alleges it was told the carrier was Aetna and that Aetna paid the claim 3/5/08. (See requestor's DWC-60 packet.)
2. Then on 9/24/08 Aetna 'retracted' the claim, the meaning of which Texas Mutual is unclear. (See requestor's DWC-60 packet.)
3. The requestor billed Texas Mutual 10/6/08. However, by then the bill was past the 95 days.

Texas Mutual believes this situation meets the requirements of section 408.0272 of the Labor Code. If the requestor can confirm it has refunded the payment to Aetna then Texas Mutual will authorize payment of the disputed services."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/10/08	No EOB from the respondent was submitted for review	Emergency Room Visit	$828.10	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective January 17, 2008 set out the reimbursement guidelines.

1. The requestor did not submit EOBs from the respondent for consideration in this dispute as required under 28 TAC §133.307(c)(2)(B) effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, which requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB". This request for medical fee dispute resolution was received by the Division on February 3, 2009. Review of the submitted documentation finds that the requestor has not provided convincing evidence of carrier receipt of a request for an EOB. The Division concludes that the requestor has not filed the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).
2. The requestor did not submit a copy of the medical bill submitted to the carrier for reconsideration as required under 28 TAC §133.307(c)(2)(A) effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, which requires that the request shall include "a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)". This request for medical fee dispute resolution was received by the Division on February 3, 2009. The Division concludes that the requestor has not filed the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
3. This dispute relates to an emergency room visit and diagnostic radiological services provided in a hospital setting with reimbursement subject to the provisions of Division Rule at 28 TAC §134.1, effective January 17, 2008, 33 TexReg 428, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, which requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… This request for medical fee dispute resolution was received by the Division on February 3, 2009. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not filed the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
6. Division Rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"... This request for medical fee dispute resolution was received by the Division on February 3, 2009. The requestor's position statement asserts that "The charges are fair and reasonable." However the requestor did not discuss or explain how it determined that the charges are fair and reasonable. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support that reimbursement at the amount of the billed charges would be fair and reasonable. Nor has the requestor discussed how payment of the amount sought would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Additionally,

a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in another fee guideline adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources." Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(B), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.